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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2010 - 357

13 **LAUREL SCHOTT**
14 **2929 Harvey Court**
Marina, CA 93933

ACCUSATION

15 **Registered Nursing License No. 427292**

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
22 of Consumer Affairs.

23 2. On or about July 31, 1988, the Board of Registered Nursing issued Registered Nurse
24 License Number 427292 to Laurel Schott ("Respondent"). The Registered Nursing License
25 expired on July 31, 2008, and has not been renewed.

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1 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
2 enforcement of the case.

3 DRUGS

4 9. "Ativan" is the brand name for Lorazepam, a depressant and Schedule IV controlled
5 substance as listed in Health and Safety Code section 11507(d)(16) and is a dangerous drug
6 pursuant to Code section 4022. It is used for the treatment of anxiety associated with depression
7 and/or acute alcohol withdrawal symptoms.

8 10. "Seroquel" is the brand name for Quetiapine Fumarate, a dangerous drug within the
9 meaning of Code section 4022. It is an antipsychotic medication used to treat acute manic
10 episodes associated with bipolar disorders or schizophrenia. Side-effects include hypotension, or
11 lowering of blood pressure.

12 FACTUAL BACKGROUND

13 11. In August 2004, Respondent was hired as a per diem nurse at Pacific Grove
14 Convalescent Hospital ("PGCH"), in Pacific Grove, California.

15 12. Respondent was on duty on October 29, 2006, as a charge nurse. Seven certified
16 nurse assistants were also assigned to the floor. Patient J.L. was a 84 year old male, diagnosed
17 with Alzheimer's and noted to have moderate cognitive deficits. Patient K.H. was a 53 year old
18 male on Hospice care, diagnosed with schizophrenia, lung and brain cancer.

19 13. Respondent completed a "Medication Error" report October 30, 2006. She therein
20 related that at 9:00 a.m., on October 29, 2006, she removed and dissolved in water the following
21 four medications for K.H.: Senokot 2 tablets (laxative), Meclizine 25 mg (for nausea),
22 Ativan 1 mg, and Seroquel 300 mg.¹ Without checking the photograph of the patient in the
23 medication book with their prescribed medications and without checking the identification band
24 on the patient's wrist, Respondent administered the above medications to J.L. instead of K.H., the
25 patient for whom the medications had been prescribed.

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27 ¹ A nurse is required at all times follow the "five rights of medication administration:"
28 right patient, right medication, right dose, right chart, and right route.

14. Respondent noted in a "Medication Error" report that it was later in the day she realized that the wrong medications had been given to J.L.

15. Prior to the morning of October 29, 2006, J.L.'s blood pressure had been normal. However, as a result of receiving the Seroquel he became severely hypotensive such that he had to be transferred to the Community Hospital of the Monterey Peninsula. His condition continued to deteriorate and he expired on November 1, 2006.

16. On April 12, 2007, Respondent by declaration gave a different scenario regarding the events on October 29, 2006. She admitted mixing in water the four medications that were intended for K.H., as referenced above in paragraph 13. However, in this scenario, Respondent related that before administering the medications she was called away to see another patient. She then gave the glass of water with the pre-mixed medications to the certified nurse assistant assigned to patient K.H. and instructed him to take the “cup of water” to K.H.’s room. Later on Respondent allegedly learned that the certified nurse assistant thought she had instructed him to take the “cup of water” to J.L., who reportedly drank all the “water.”

17. Respondent acknowledged in her declaration that as a Registered Nurse, she was ultimately responsible for J.L. receiving the medications intended for K.H.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to disciplinary action for gross negligence pursuant to Code section 2761(a)(1), in that she failed to follow the standards of practice with regard to the administration of patient medications, and as a result Respondent gave J.L. the medications prescribed and intended for K.H. , as set forth in paragraphs 11 through 15, and 17, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

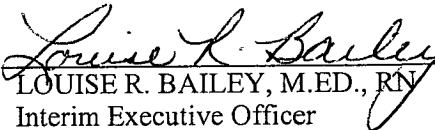
19. Respondent is subject to disciplinary action for gross negligence pursuant to Code section 2761(a)(1), in that she failed to follow the standards of practice with regard to the administration of patient medications and as a result a certified nursing assistant gave J.L. the medications prescribed and intended for K.H., as set forth in paragraphs 11 through 17, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 427292, issued to Laurel Schott.
2. Ordering Laurel Schott to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
3. Taking such other and further action as deemed necessary and proper.

DATED: 1/25/10


LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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